Optum

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY | LIVE WELL SAN DIEGO

September 2022

Medi-Cal Fee for Service Documentation Requirement Updates

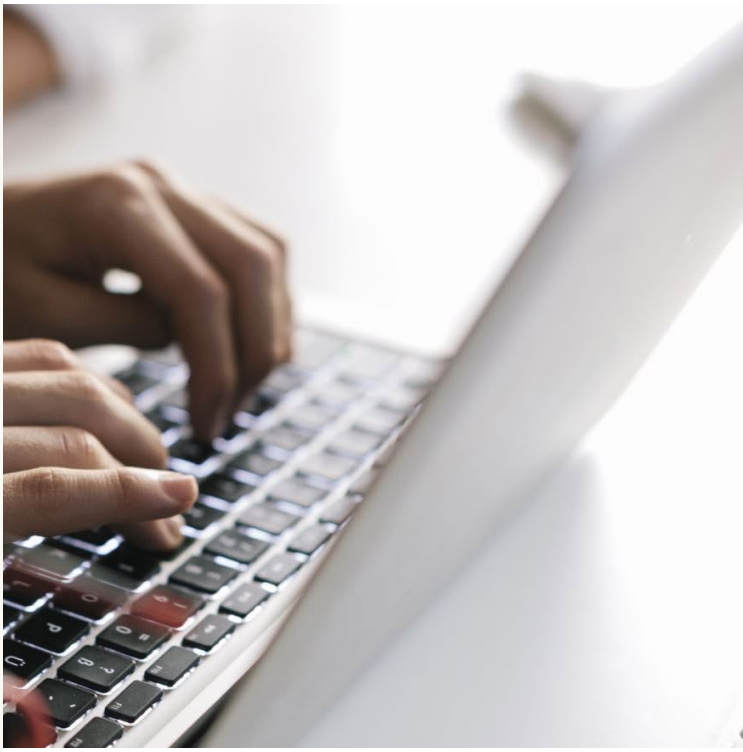
Greetings from Provider Services

Recently, the California Department of Healthcare Services released new requirements for documenting behavioral health services. The goal of these changes is to improve the client experience; effectively document treatment goals and outcomes; promote efficiency to focus on delivering person-centered care; promote safe, appropriate, and effective client care; address equity and disparities; and ensure quality and program integrity.

To make the changes easier, we are highlighting the documentation and authorization request changes relevant to our Medi-Cal fee-for-service providers in this edition of our newsletter.

Please don't hesitate to reach out to the Provider Services or Utilization Management teams should you have questions regarding any of these changes. We invite you to join us for a virtual open house on September 16 where you may ask questions. See page 7 for more information.

Thank you for your dedication to our San Diego Medi-Cal clients and the great work you do to serve our community.



Newsletter Content

Contact Numbers

San Diego Access and Crisis Line	(888) 724-7240
Medi-Cal Provider Line	(800) 798-2254
TERM Provider Line	(877) 824-8376

optumsandiego.com

Funding for services is provided by the County of San Diego Health & Human Services Agency

Assessment Domains

All providers are required to use the following seven domains in their assessments. For clients under the age of 21, the Child and Adolescent Needs and Strengths (CANS) Assessment tool may be utilized to help inform the assessment domain requirements.

Domain 1:
- Presenting Problem(s)
- Current Mental Status
- History of Presenting Problem(s)
- Beneficiary-Identified Impairment(s)

Domain 2:
- Trauma

Domain 3:
- Behavioral Health History
- Comorbidity

Domain 4:
- Medical History
- Current Medications
- Comorbidity with Behavioral Health

Domain 5:
- Social and Life Circumstances
- Culture/Religion/Spirituality

Domain 6:
- Strengths, Risk behaviors, and Safety Factors

Domain 7:
- Clinical Summary and Recommendations
- Diagnostic Impression
- Medical Necessity Determination/Level of Care/Access Criteria

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The assessment must include your determination of medical necessity and recommendation for services. The problem list and progress note requirements (further discussed in this newsletter) should support the medical necessity of each service provided.

As always, be sure your assessment includes a typed or legibly printed name, provider signature, and date of signature.

Click **HERE** to access the Optum Assessment Template

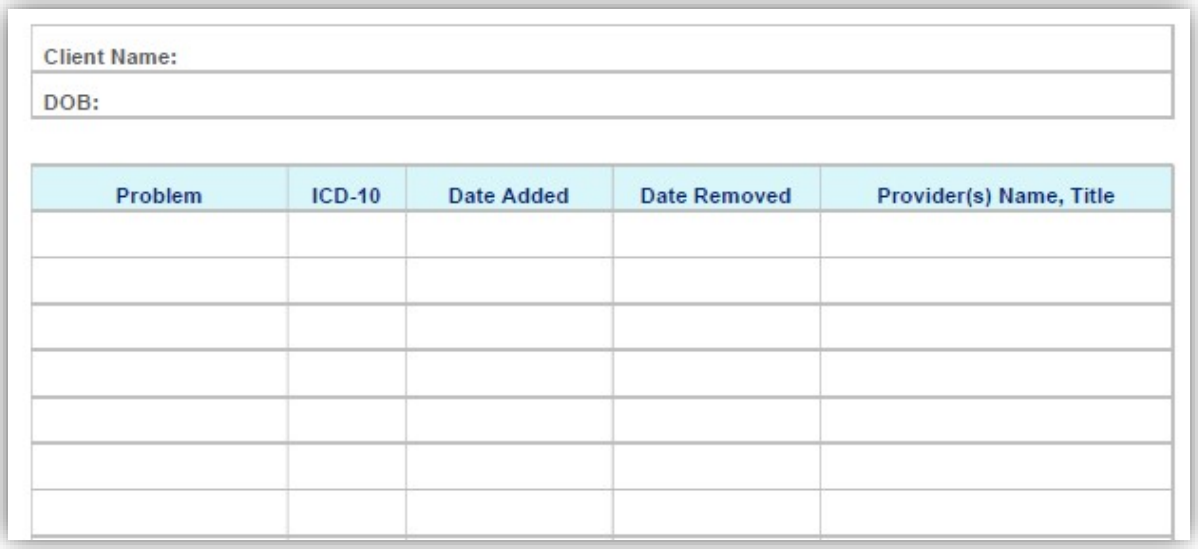
Problem List

The California Department of Healthcare Services now requires all Medi-Cal providers to create and maintain a Problem List for each client. The problem list is created during initial assessment and updated throughout the client's treatment when there is a relevant change to the client's condition.

The problem list may include the following:

- Diagnoses identified by the provider acting within their scope of practice. Include diagnosis-specific specifiers from the current DSM when applicable
- Problems identified by the provider acting within their scope of practice
- Problems or illnesses identified by the client and/or a significant support person

For each problem, the date the problem is added and the date the problem is removed will be recorded along with the name and title of the provider that identified, added, or removed the problem.



Client Name:

DOB:

Problem	ICD-10	Date Added	Date Removed	Provider(s) Name, Title

We have created a Problem List template you can use in your client records. Download it from the Optum San Diego website by clicking **HERE**.

Progress Note Requirements

A progress note must be created for each service within three business days of providing the service. Each progress note should provide sufficient detail to support the service code selected as indicated by the service code description.

Progress Note Essentials:

- The type of service rendered
- A narrative describing the service, including how the service addressed the client's behavioral health need (e.g., symptom, condition, diagnosis, and/or risk factors)
- The date the service was provided
- Duration of the service
- Location of the client at the time of receiving the service
- A typed or legibly printed name, signature of the service provider and date of signature
- Service codes. The appropriate ICD-10 and HCPCS/CPT codes must appear in the clinical record, associated with each encounter and consistent with the description in the progress note
- Next steps including, but not limited to:
    - planned action steps by the provider or by the client
    - collaboration with the client
    - collaboration with other provider(s)
    - any update to the problem list as appropriate

Care Coordination Activities

Care coordination supports the client's efforts to achieve and maintain the highest possible level of stability and independence. Providers are required to coordinate the client's mental health services and refer the client to appropriate community services.

You will notice the new fee schedule and authorization request form include the Healthcare Common Procedure Coding System (HCPCS) code T1017, Targeted Case Management. These services may be provided to assist a client with access to needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. The service activities may include, but are not limited to, communication, coordination, and referral; monitoring service delivery to ensure client access to service and the service delivery system; monitoring of the client's progress; placement services; and plan development.

When requesting authorization for case management services, select the assistance area and indicate the plan for assisting the client with that area.

Targeted Case Management (T1017, 1 unit = 15 minutes)			
Targeted Case Management will focus on: ☐ Medical, Explain: ☐ Social, Explain: ☐ Educational, Explain: ☐ Other Services, Explain:			

Updates to Authorization Requests for Medication Services

To promote efficiency, we have updated the outpatient authorization request form (OAR) by reducing the number of fields and adding seven prompts to assist providers in meeting the new documentation requirements. You will find the new request form is shorter and has more checkboxes for your convenience.

The new request form is effective October 1, 2022. However, you may begin using the new form immediately. Please note that old versions of the authorization request form received after October 31, 2022, will be returned with notification to complete the request on the new authorization request form.

Added Items

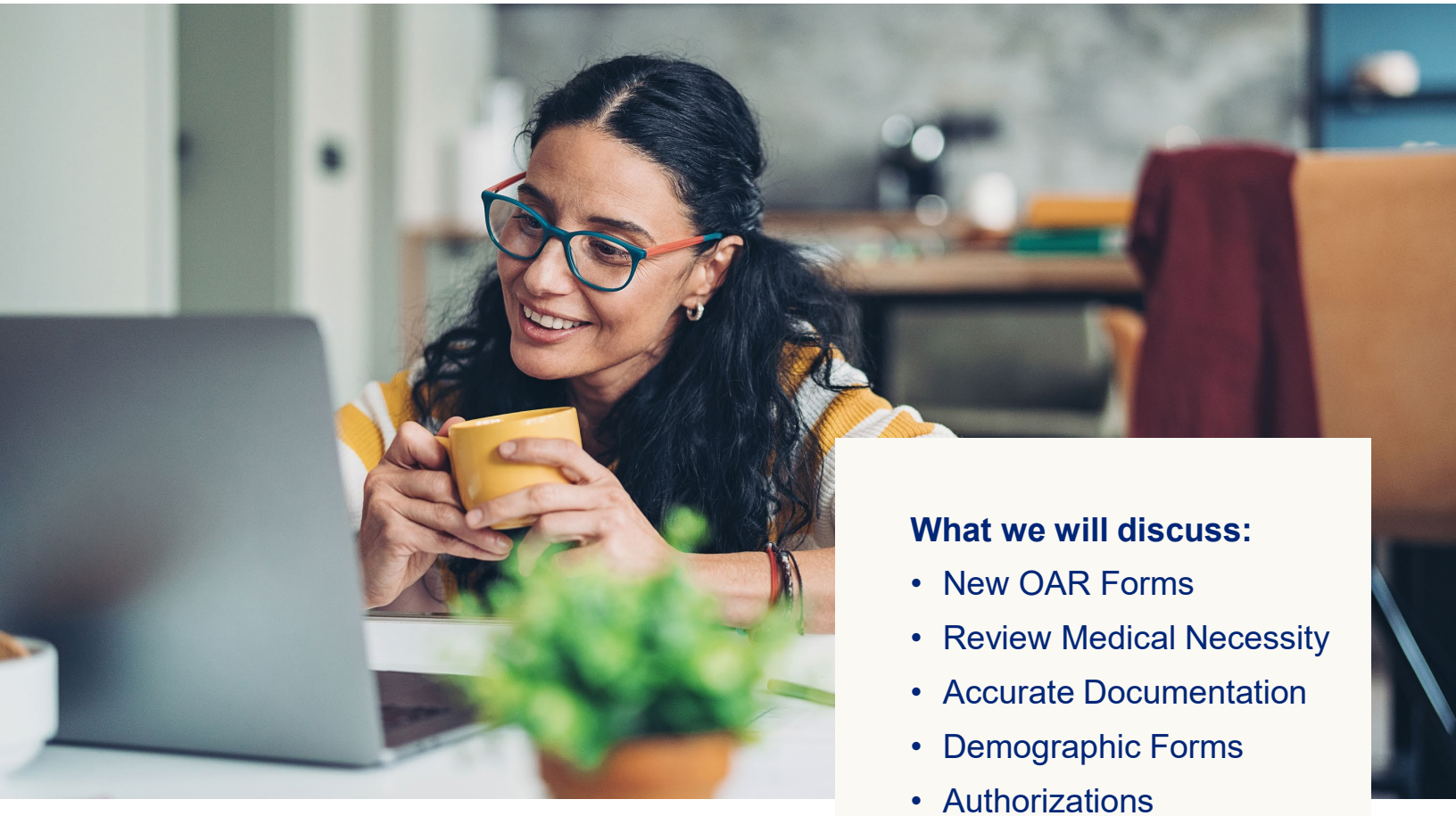
1. Client ethnicity
2. Living situation
3. Current employment/school status
4. Problem list review/update checkbox date
5. Significant impairment prompts
6. Targeted Case Management plan (if needed)
7. Explanation if no medications are currently prescribed

Removed Items

- Current health plan
- If Child, current IEP
- Symptom severity
- Current treatment provided by others
- Progress
- Expected length of treatment
- Referrals made to others
- Client signature

Click **HERE** to access the new Authorization Request for Medication Services

Come join us for a virtual open house!



What we will discuss:

- New OAR Forms
- Review Medical Necessity
- Accurate Documentation
- Demographic Forms
- Authorizations
- Q & A

Friday September 16th, 2022
9:30AM – 10:30AM

RSVP by September 14th, 2022
1-800-798-2254 Option 3, then 4

Telehealth Consent

Providers must confirm consent for the telehealth (synchronous audio or video) or telephone service, in writing or verbally, at least once prior to initiating services.

Consents must include:

- Explanation that clients have the right to access covered services that may be delivered via telehealth through an in-person, face to face visit
- Explanation that telehealth use is voluntary and that consent for the use of telehealth can be withdrawn at any time by the client without affecting their ability to access Medi-Cal services in the future
- Potential limitations or risks related to receiving services through telehealth as compared to an in-person visit, to the extent any limitations or risks are identified by the provider

The client's verbal or written acknowledgement that the information was received must be documented in the client record.

When submitting claims for telehealth sessions please note the following Place of Service (POS) codes:

POS 02: Telehealth Provided Other than in Patient's Home

POS 10: Telehealth Provided in Patient's Home